Exhibit A – Plaintiff Fact Sheet

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No. 1:09-MD-02051-ALTONAGA

IN RE DENTURE CREAM PRODUCTS
LIABILITY LITIGATION -- MDL-2051,

This Document Relates To All Actions

THIS RELATES TO MDL DOCKET 2051

PLAINTIFF: _____
Name(s)

PLAINTIFF FACT SHEET

Please provide, to the best of your knowledge and ability, the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the questions in sections I (A), I (B), and II through XIII with respect to the person by whom Denture Adhesive Cream was allegedly used ("Denture Adhesive Cream User" or "User"). In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you cannot recall or determine the exact date(s) requested, then please provide your best approximation. To the extent you recall details after you submit your fact sheet, you are obligated to supplement your fact sheet with the additional information. *Please attach as many additional sheets of paper as are necessary to fully and completely answer these questions*.

In filling out this form, please use the following definitions and instructions:

(1) "Health Care Provider" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, nursing, dietary, and any pharmacy, x-ray department, laboratory, physical therapist or physical therapy department, radiologist or radiology group, dermatologist, surgeon, x-ray department or facility, rehabilitation specialist or facility, physician, osteopath, homeopath, chiropractor, podiatrist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you. "Health Care Provider" as defined herein does not include a purely "consulting expert" (as interpreted and defined by governing rules, and subject to the provisions and limitations of the Federal Rules of Civil Procedure) who: (1) has been specifically retained by your counsel in this Lawsuit to evaluate or diagnose your medical and/or mental condition; *and* (2) has not, outside of this retained role, ever been involved in your evaluation, diagnosis, care and/or treatment.

(2) "Oral Health Care Provider" means any dentist, oral surgeon, endodontist, periodontist, prosthodontist, denturist, orthodontist, dental hygienist, other provider of dental or

oral health care, as well as any dental office, facility or clinic that is associated with such persons.

(3) "Document" means any writing or record of every type that is in your possession, custody or control, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phone records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

I. Case Information

A. Name of person completing this form: _____

B. Please state the following for the civil action that you filed:

1. Name of the Denture Adhesive Cream User:_____

2. Case caption:_____

3. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

_____
Name

_____
Firm

_____
Street Address

_____
City, State and Zip Code

_____
Telephone Number Fax Number

_____
E-mail address

C. If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person, incapacitated person, or a minor), please state:

1. Your name:_____

2. Address:_____

3. In what capacity you are representing the individual:_____

4. If you were appointed by a court, state the court and date of appointment:_____
_____

5. Your relationship to deceased or represented person:_____

6. If you represent a decedent's estate, state the date of death of decedent:_____

II. Personal Data of the Denture Adhesive Cream User[1]

A. Maiden name or any other names used and dates of use:_____

B. Identify each address at which you have resided since 1995 to the present, starting with your current address, and list when you started and stopped living at each address:

Address	Dates of Residence

C. Driver's License Number and State Issuing License:_____

D. Social Security Number:_____

E. Date and place of birth:_____

F. Sex: Male_____ Female_____

G. For your current and each former marriage, please list the following information for each spouse:

Name and Current Address of Spouse, if known	Date of Birth	Date of Marriage, if applicable	Date Marriage Ended, if applicable	How Marriage Ended	Occupation (current spouse only)

H. Has your spouse filed a loss of consortium claim in this action? Yes_____ No_____

[1] In sections II through XIV, the Denture Adhesive Cream User is also referred to as "User," "you" or "your."

I. For each of your children, state his/her name, age, and state of residence: _____

_____

_____

J. Employment Information.

Beginning with your current employer (if not currently employed, last employer), list the following for each employer you have had since 1995 to the present:

Name	Address	Dates of Employment	Job Title

K. Education. Please identify the schools you have attended (high school and beyond):

Name of School	Address	Dates of Attendance	Degree or Diploma Awarded and Date Received	Major or Primary Field of Study

L. Have you ever applied for worker's compensation, social security, or state or federal disability benefits? Yes_____ No_____

If "yes," then as to each application, separately state:

1. Date (or year) of application, type of benefits, and the reason for your claim:_____

_____

2. Amount awarded or stated reason for denial, if denied:

_____

3. To what agency or company did you submit your application (for example, Pennsylvania Division of Social Security):_____

M. Have you ever been out of work for more than thirty (30) days in any one (1) year for reasons related to your health condition (other than pregnancy)? Yes_____ No_____

If "yes," please state the dates you were out of work, your employer, if any, on those dates, and describe the condition(s) that kept you from working:

_____

_____

_____

N. Have you ever served in the U.S. Military? Yes ____ No____

If "yes," were you ever rejected or discharged from military service for any stated reason relating to your health, physical, emotional or psychiatric condition? Yes_____ No_____

If "yes," describe the condition and the date upon which you were rejected or discharged from military service, and identify the military branch in which you were serving, or were considered for service, at that time. _____

_____

_____

O. Within the past 20 years, have you filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, sickness or disease? Yes_____ No_____

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit. _____

_____

Have you *ever* filed a lawsuit or made a claim, other than in the present suit, relating to the same or similar injuries or conditions you claim in this case? Yes_____ No_____

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit. _____

_____

P. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to *any* crime that involved an alleged act of dishonesty or providing a false statement? [Rule 609 Federal Rules of Evidence] Yes_____ No_____

If "yes," state the date of such conviction or plea, the court in which such conviction or plea was entered and the nature of the felony and/or other crime. _____

_____

III. Oral Health Care Providers of the Denture Adhesive Cream User

A. Please list to the best of your knowledge every Oral Health Care Provider (beginning with your *current* dentist) whom you have seen or from whom you have ever received oral or dental care or treatment (including fitting and treatment for dentures, repair

and/or replacement of dentures) since 5 years before you first got denture(s) to the present. Please **circle** the Name of the Oral Health Care Provider that you ***last*** saw for any reason.

Full Name and Specialty, if any	**Complete Address**	**Treatment Provided**	**Approximate Dates**

IV. Dentures

A. Use of Dentures

1. Reason you use dentures:

   a. Please describe in your own words why you need dentures (for example, an accident causing tooth loss (describe accident), loss of tooth enamel or bone, mouth or gum disease, lack of oral hygiene, or other reason). _____
   _____
   _____
   _____

   b. If any Oral Health Care Provider or Health Care Provider told you about a medical or oral condition requiring you to use dentures, please state the Provider's full name and address, the date(s) the Provider informed you, and what you were told by the Provider. _____
   _____
   _____
   _____

2. Please provide the following information for any tooth extraction done in preparation for denture use:

   a. number of teeth extracted: _____

   b. location of teeth extracted: _____

   c. name of Oral Health Care Provider or Health Care Provider performing extraction: _____

   d. date of extraction: _____

3. Date of first use of dentures: _____

4. Date of last use of dentures (if ongoing, please state): _____

5. State the type of dentures you wear/have worn and the approximate beginning and ending dates you wore each: (a) uppers only; (b) lowers only; (c) both uppers and lowers; (d) partials; (e) other (please specify):_____
_____
_____
_____

6. The last date you saw an Oral Health Care Provider *regarding your dentures* and the name of the Provider seen: _____
_____

V. Denture Adhesive Creams

A. With respect to your use of *any* Denture Adhesive Cream at any time (including but not limited to Poligrip and/or Fixodent)

Please answer the following:

Brand *and* Type of each Denture Adhesive Used	Date of First Use and Dates of Any Later Use	Name(s) of Oral Health Care Provider(s), if any, that you were seeing during the time period you indicate in Column 2

B. Prior to or during your use of any denture adhesive cream, were you given any information by any Oral Health Care Provider(s) or Health Care Provider(s) regarding use of denture adhesive cream (information may include oral or written instructions, directions, advice, warnings, or other types of information)? Yes_____ No_____

If yes, please state:

1. The date(s) on which such oral instructions, directions, advice, warnings, or other information regarding use of denture adhesive cream were given to you:
_____
_____

2. Name and address of any Oral Health Care Provider or Health Care Provider who gave the oral instructions, directions, advice, warnings or other information regarding use of denture adhesive cream to you:_____

_____

_____

3. To the best of your ability, describe what you were told about the use of denture adhesive cream by *each* Oral Health Care Provider or Health Care Provider you identified in 2 above. _____
Provider 1 [Name of Provider and Information Given]:_____

_____

_____

Provider 2 [Name of Provider and Information Given]:

_____

_____

Provider 3 [Name of Provider and Information Given]: _____

_____

_____

VI. Medical Background of the Denture Adhesive Cream User

A. General Background

1. Height: _____

2. Current Weight: _____

B. Smoking/Tobacco Use History

1. Ever smoked cigarettes? Yes ____ No ____

   a. If "yes," provide the date you started smoking:_____

2. Current smoker of cigarettes? Yes ____ No ____

   a. If "yes," state the number of packs smoked per day:_____

3. Former smoker of cigarettes? Yes_____ No_____

   a. If "yes," provide the date you permanently stopped smoking:_____

   b. If "yes," state the number of packs smoked per day before you permanently stopped:_____

4. Any other form of tobacco use (pipe tobacco, snuff, chewing tobacco, dipping, cigars)? Yes_____ No_____

a. If "yes," then state what form, dates of use, and amount of use as to each:

_____

5. Has the number of cigarettes smoked per day, or other daily tobacco use, changed over the last 5 years? Yes_____ No_____

a. If "yes," then please briefly describe the change in usage of each:

_____

_____

C. Alcohol Consumption

1. Have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____

a. If "yes," provide the date you started consuming alcohol:

_____

2. Do you currently drink alcohol? Yes ____ No ____

a. If yes, check below which best describes your alcohol consumption.

_____ Less than 1 drink per week
_____ Less than 1 drink per month
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per week
_____ 20-30 drinks per month
_____ 30-40 drinks per month
_____ Over 40 drinks per month

b. If you have ever but do not currently drink alcohol, check below which best describes your former alcohol consumption.

_____ Less than 1 drink per week
_____ Less than 1 drink per month
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per week
_____ 20-30 drinks per month
_____ 30-40 drinks per month
_____ Over 40 drinks per month

3. If you have ever but do not currently drink alcohol, provide the date you last consumed any alcohol: _____

4. Has your weekly or monthly alcohol consumption pattern changed over the last 5 years? Yes_____ No_____

   a. If "yes," then please describe the change:_____

_____

_____

D. Illicit Drugs

1. Have you ever used marijuana regularly (more than once a month) during a period of 3 or more consecutive months? Yes_____ No_____ Don't Recall_____

   a. If "yes," please state how often you used it, and the date of your last use:

_____

_____

2. Have you ever regularly used (more than once a month) any illicit drugs, other than marijuana, during a period of 3 or more consecutive months (examples include but are not limited to: cocaine/crack cocaine; heroin, opiates, or methadone; hallucinogens such as LSD, Ecstasy, ICE, PCP, MDMA or similar substances; amphetamines, crystal meth, or other stimulants; barbiturates or other sedatives)?

   Yes_____ No_____

   If "yes," please state what you used, how often you used it, and the date of your last use:_____

_____

E. Nutritional History

1. Have you ever followed any special diets or dietary restrictions for more than 3 consecutive months, for example, for the purpose of weight loss, a health condition such as diabetes or high blood pressure, allergic reactions, or other reason? Yes ___ No ___

   If "yes," for each type of diet listed below, give a general description of the diet, the dates you followed that diet, the reason for the diet (for example, to lose weight; to control blood pressure, diabetes, or allergies; to correct nutritional or other imbalance), whether the diet was prescribed or recommended by a health care provider, and if so, the name of the health care provider.

   a. Diet or nutritional program you designed yourself:

_____

_____

_____

b. Physician-prescribed diet:

_____

_____

_____

c. Any other diet program (examples include Adkins, South Beach, Pritikin, Jenny Craig, Weight Watchers, vegetarian, low fat, high protein, gluten-free, etc.)

_____

_____

_____

2. Do you regularly drink soda or other carbonated beverages? Yes ____ No ____

If "yes," please state the type of the soda you drink, whether diet or regular, and the amount of soda you drink per day. _____

_____

_____

_____

F. To the best of your knowledge have you ever suffered from or been diagnosed by a doctor or other health care provider with:

		Yes	No	I Don't Recall
1.	Anemia	_____	_____	_____
2.	Leucopenia	_____	_____	_____
3.	Neutropenia	_____	_____	_____
4.	Hypocupremia or Copper Deficiency	_____	_____	_____
5.	Hyperzincemia or Zinc Overload	_____	_____	_____
6.	Vitamin B12 Deficiency	_____	_____	_____
7.	Other Vitamin Deficiency	_____	_____	_____
8.	Myelodysplasia	_____	_____	_____
9.	Myelofibrosis	_____	_____	_____
10.	Diabetes	_____	_____	_____
11.	Wilson's Disease	_____	_____	_____
12.	Menkes' Disease	_____	_____	_____
13.	Myasthenia Gravis	_____	_____	_____
14.	Multiple Sclerosis	_____	_____	_____
15.	Parkinson's Disease	_____	_____	_____
16.	Amyotropic Lateral Sclerosis (ALS; Lou Gehrig's Disease)	_____	_____	_____
17.	Alzheimer's Disease	_____	_____	_____
18.	Cancer/Malignancy	_____	_____	_____
19.	Uremia	_____	_____	_____
20.	Liver Disease	_____	_____	_____

21.	Rheumatoid Arthritis	_____	_____	_____
22.	Celiac Disease	_____	_____	_____
23.	Inflammatory Bowel Syndrome or Disease	_____	_____	_____
24.	Small Intestine/Bowel Bacterial Overgrowth	_____	_____	_____
25.	Other Malabsorption or Gastrointestinal Disorder	_____	_____	_____
26.	Short Bowel Syndrome	_____	_____	_____
27.	Gastric or Intestinal Ulcers	_____	_____	_____
28.	Aceruloplasminemia	_____	_____	_____
29.	Any Immunologic or Autoimmune disorder	_____	_____	_____
30.	Head, Neck, or Back Trauma or Injury	_____	_____	_____
31.	Brain Injury	_____	_____	_____
32.	Cognitive Deficits	_____	_____	_____
33.	Injury to Spinal Cord	_____	_____	_____
34.	Disease or injury of vertebra or disc	_____	_____	_____
35.	Occipital Horn Syndrome	_____	_____	_____
36.	Subacute Combined Degeneration of the Spinal Cord	_____	_____	_____
37.	Myelopathy (disease or injury of spinal column)	_____	_____	_____
38.	Neuropathy or Peripheral Neuropathy (disease or injury to nerves other than spinal column)	_____	_____	_____
39.	Myeloneuropathy or Combined Systems Disease	_____	_____	_____
40.	Anorexia Nervosa	_____	_____	_____
41.	Bulimia Nervosa	_____	_____	_____
42.	Malnutrition	_____	_____	_____
43.	Any Neurologic (nerve) Disease or Disorder	_____	_____	_____
44.	Any Hematologic (blood) Disease or Disorder	_____	_____	_____

If "yes," please state separately for each:

Type of Condition	**Date of First Symptoms**	**Date of Diagnosis**	**Diagnosing Doctor**

G. Have you ever undergone dialysis, tube feeding, and/or intravenous feeding? If so, please provide the reason(s) for such treatment, and frequency and dates of such treatment: _____

_____

_____

H. Have you ever had bariatric, gastrointestinal and/or other weight loss surgery? If so, please provide the reason(s) for the surgery, the date of the surgery, the name of the surgeon who performed the surgery, and the facility at which the surgery was performed:

_____

_____

_____

VII. Medications, Vitamins, or Supplements Used by the Denture Adhesive Cream User

To the best of your knowledge, state whether you used any of the following medications, vitamins or supplements at any time beginning 5 years before your first use of any denture adhesive cream to the present OR in the past 15 years, whichever date is earlier. Circle all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication, vitamins or supplements.

Medication	Dates Used (first to last use)	Prescribing Doctor, if applicable	Reason for Use/Prescription, if applicable
Any Multivitamin preparation (including but not limited to Centrum, One-A-Day, Stuart, Oncovite, Nature Made, Stresstabs, Weil, Prescriptive Formulas, Vitafusion, Viactiv, Rite Aid, Walgreens, Twinlab, Geritol, Natrol)			

Medication	Dates Used (first to last use)	Prescribing Doctor, if applicable	Reason for Use/Prescription, if applicable
Any supplements, sprays, swabs, lozenges, or other products containing Zinc (including but not limited to GNC Zinc 50, GNC Zinc 100, ICaps, Ocuvite, Sunkist Zinc Throat Lozenges, Tung Gel, Zand Herbalozenge, GNC Ultra Zinc Lozenges, Cold-Eeze, TheraBreath Chewing Gum, EAS Myoplex, Zicam Cold Remedy Nasal Gel or Gel Swaps, Zicam Cold Remedy, Zicam Healthy Z-ssentials)			
Any and all other prescription and non-prescription medications, including vitamin supplements, herbal supplements or remedies, or homeopathic remedies.			
Name:_____ _____ _____ _____ _____ _____ _____ _____ _____ _____			

VIII. Injuries, Symptoms, Diagnoses, Ailments, and Damages of the Denture Adhesive Cream User

A. Are you claiming that you have developed or may develop any injury or damage or condition (including any alleged physical, injury or damage) as a result of using denture adhesive cream? Yes_____ No_____

If "yes," then for ***each*** such injury, damage or condition, answer the following:

1. Describe each injury, damage or condition that you are claiming was caused by your use of any Denture Adhesive Cream, including in your description the date you became aware of each injury, damage or condition:

_____
_____
_____
_____
_____

2. Describe all of the symptoms you are experiencing that you claim result from use of denture adhesive cream.

_____
_____
_____
_____
_____

3. For each of the symptoms you describe in No. 2 above, going back ten (10) years from your first use of dentures, when was the ***first time*** (the earliest date) you can remember ever having that symptom, , even if the symptom went away:

Symptom:_____
First Time (earliest date):_____

Symptom:_____
First Time (earliest date):_____

Symptom:_____
First Time (earliest date):_____

Symptom:_____
First Time (earliest date):_____

4. For each such injury, damage, condition, or symptom that you have described in this Section VIII (A) (1-2) above, have you consulted with any Health Care Provider(s) or Oral Health Care Provider(s) with respect to your alleged denture adhesive cream-related injury(ies)? Yes_____ No_____

If "yes," for each Health Care Provider or Oral Health Care Provider, state:

Name of Health Care Provider or Oral Health Care Provider	**Address of Health Care Provider or Oral Health Care Provider**	**Dates of Consultation/Treatment and Nature of Injury, Damage, Condition or Symptom**

B. Did you ever suffer from these types of injuries, damages, or conditions, or have any symptoms of these types of injuries, damages, or conditions, prior to your use of denture adhesive cream? Yes_____ No_____

If "yes," for each such injury, damage, condition or symptom, state:

Description of Injury, Damage, Condition or Symptom	**Date(s) You Had the Injury, Damage, Condition or Symptoms**	**Health Care Provider or Oral Health Care Provider Visited, if any**	**Dates of Consultation/Treatment with Health Care Provider or Oral Health Care Provider, if any**

C. Have you ever undergone any of the following medical tests?

1. Magnetic Resonance Imaging (MRI) of the brain: Yes_____ No_____

2. Magnetic Resonance Imaging (MRI) of the spine: Yes_____ No_____

3. Electromyogram (EMG): Yes_____ No_____ Unsure _____

4. Evoked Potentials Tests (including but not limited to Somatosensory Evoked Potentials (SSEP) tests): Yes_____ No_____ Unsure _____

5. Nerve Conduction Velocity Study (NCVS): Yes_____ No_____ Unsure_____

If "yes" to any of the above, please state for *each*:

a. The name of *each* test:
_____
_____

b. The date *each* test was ordered: _____
_____

c. The Health Care Provider that ordered *each* test: _____
_____
_____

d. The date and location where *each* test was administered: _____
_____
_____

e. Your best knowledge and information as to whether *each* test showed any problem, and, if so, what each test showed and/or what you were told by any Health Care Provider that each test showed:_____
_____
_____
_____

D. Do you allege that the use of denture adhesive cream aggravated a pre-existing condition?
Yes_____ No_____

If "yes," for each such pre-existing condition, state:

a. A Description of the Pre-Existing Condition: _____
_____
_____

b. The date when any pre-existing condition first arose:_____
_____
_____

c. The date any pre-existing condition was first diagnosed:_____
_____
_____

d. The name and address of any healthcare provider or oral health care provider who provided care for any pre-existing condition: _____
_____
_____

E. Have you ever had laboratory work performed that measured your whole blood, serum, plasma, or urine levels for zinc, copper and/or ceruloplasmin?
Yes_____ No_____ Unsure _____

If "yes," then based on your best recollection, separately state for zinc, copper and/or ceruloplasmin *each* time they were measured:

a. The zinc, copper and/or ceruloplasmin level(s) found and whether the level(s) were low, normal or high. (If specific level is unknown, please provide/describe your best knowledge and information about whether the result(s) were low, normal, or high as to each test performed and/or what you were told as to whether your zinc and/or copper level(s) were low, normal or high):_____
_____
_____
_____

b. The date(s) the blood was drawn (or urine sample provided):_____
_____
_____

c. The lab or facility that performed the test:_____
_____

d. The type of test (whole blood, serum, plasma, or urine):_____
_____

F. Has any Health Care Provider or Oral Health Care Provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages, conditions, or symptoms that you describe in this Section VIII above are associated with your use of any denture adhesive cream? Yes_____ No_____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:
_____
_____
_____

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

_____

_____

_____

G. Has any Health Care Provider or Oral Health Care Provider ever told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you describe in this Section VIII above are associated with any factors *other than* your use of any denture adhesive cream? Yes_____ No_____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:

_____

_____

_____

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

_____

_____

H. Excluding future medical expenses are you claiming that you have paid or will have to pay any expenses as a result of having used any denture adhesive cream? Yes_____ No_____

If "yes," then for each item separately identify:

Reason Expense was Incurred	**Amount of Fees or Expenses**	**Person or Company Paid or to be Paid**

I. Are you claiming to have suffered any mental anguish or emotional injury as a consequence of using any denture adhesive cream?

Yes_____ No_____

If "yes," have you received any counseling/care/treatment by any mental health care provider for the mental anguish or emotional injury you are claiming?

Yes___ No___

If "yes," then state:

The full name, address and specialty of each mental health care provider you have seen for the mental anguish or emotional injury you are claiming, and the approximate date(s) of any visits with each: _____

_____

_____

J. Do you claim psychological or psychiatric injury (other than the mental anguish or emotional distress described above) as a consequence of using any denture adhesive cream.

Yes___ No___

If "yes," have you received any counseling/care/treatment by any mental health care at any time for any psychological or psychiatric conditions?

Yes___ No___

If "yes," then state:

The full name, address and specialty of each mental health care provider you have *ever seen for any reason* and the approximate date(s) of any visits with each:_____

_____

_____

_____

K. Fact Witnesses

Please identify all persons who you believe possess information concerning your claimed injury(ies) and damages other than your Healthcare Providers and/or Oral Healthcare Providers, and please state their name address and his/her/their relationship to you:

Name:_____

Address:_____

_____

Relationship to you:_____

Name:_____

Address:_____

_____

Relationship to you:_____

Name:_____

Address:_____

_____

Relationship to you:_____

IX. Family History of the Denture Adhesive Cream User

A. To the best of your knowledge did any child, parent, sibling, or grandparent of the Denture Adhesive Cream User have any of the conditions or experiences identified in Section VI (F) beginning on page ____?

Yes_____ No_____ Unsure _____

B. If "yes," or "unsure," then based on your best recollection, state separately for each: person the relationship to you, the type of health problem, and the date and cause of death (if applicable): _____
_____
_____
_____
_____

X. Health Care Providers of the Denture Adhesive Cream User

A. Provide the requested information for each of the following Health Care Providers and health care facilities:

Beginning with your current family and/or primary care physician(s), please list your family and/or primary care physicians in the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Approximate Dates

B. Provide the requested information for each hospital, clinic, or health care facility where you have received inpatient or outpatient treatment (including treatment in an emergency room) or been admitted as a patient during the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received

C. Provide the requested information for each surgery or operation that you have ever undergone, including oral surgery but not including surgery related to childbirth.

Name and Address of Hospital, Treating Physician and Surgeon	Type of Surgery or Operation	Date of Surgery or Operation	Reason for Surgery or Operation

D. Provide the information requested for every other Health Care Provider (as defined at beginning of this questionnaire) or facility (not identified in A-C above) whom you have seen or consulted or from whom you have received treatment, evaluation, or testing for *any* reason, or at which you've been treated, evaluated or tested for *any r*eason, during the time period of 10 years preceding your first use of dentures to the present.

Name and Specialty, if any	Address	Dates of Treatment/ Admission/ Visit	Reason for Treatment/ Admission/Visit	Treatment Received

E. Provide the requested information for each pharmacy that has dispensed medication to you for the time period of 10 years preceding your first use of dentures to the present:

Name	**Address**	**Years When You Used Pharmacy**

XI. Insurance Providers of the Denture Adhesive Cream User

A. Have you ever had health, prescription, dental, disability, or worker's compensation insurance coverage at any time? Yes ____ No _____

If "yes," then as to each insurance provider, please provide:

Insurance Provider Name and Address/ Telephone Number, if available	**Name and Address of Policy Holder/Insured (if different than you)**	**Subscriber/ Group ID Number and Policy/ Identification Number**	**Approximate Dates of Coverage**	**Type of Coverage (e.g., health, dental, comp)**

B. Have you ever been denied health, dental, or disability insurance coverage? Yes_____ No_____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known. _____
_____
_____

C. Have you ever been denied life insurance? Yes_____ No_____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known. _____
_____
_____

XII. Use of Poligrip

If you have used Poligrip denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

A. Date of first use of Poligrip: _____

B. Date of last use of Poligrip (if ongoing, please state): _____

C. If you have discontinued your use of Poligrip, state the reason you stopped using Poligrip:

_____

_____

1. If you discontinued your use of Poligrip, were you advised to stop using Poligrip by a Health Care Provider or Oral Health Care Provider? Yes _____ No_____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: _____

_____

D. Did you use Poligrip continuously during the time period described in (A) and (B) above?

_____

E. If you did not use Poligrip continuously, state the dates or time periods you used Poligrip:

_____

_____

_____

F. The type(s) of Poligrip you normally use or used (for example, Super Poligrip Original, Super Poligrip Free, Super Poligrip Ultra Fresh, Super Poligrip Extra Care with Poliseal, or other): _____

_____

G. The tube size of Poligrip you normally purchase or purchased (for example, 2.4 oz [68g], 1.4 oz [40g], or other):_____

_____

H. If you have used more than one type of Poligrip, state the type of Poligrip and the approximate dates or time periods of use of each: _____

_____

_____

_____

_____

I. The number of times per week you use/used Poligrip (and, if different over time, describe and provide the dates or time periods of each such usage):_____

_____

J. For your ***upper*** denture, the number of times per day you apply/applied Poligrip to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____
_____
_____

K. For your ***lower*** denture, the number of times per day you apply/applied Poligrip to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____
_____
_____

L. Did you or do you clean your dentures before each application of Poligrip? Yes___ No___ Sometimes ___

1. If you answered yes or sometimes, please describe your denture cleaning process: _____
_____
_____

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Poligrip? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Poligrip with each appliance: _____
_____
_____

N. Every store or pharmacy where Poligrip was purchased by you or on your behalf and the approximate dates of purchase: _____
_____
_____
_____
_____

O. Identify every Oral Health Care Provider from whom you received Poligrip: _____
_____
_____

P. The number of 2.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 2.4 oz tube every 10 days):_____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

Q. The number of 1.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 1.4 oz. tube every 10 days)

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

R. Briefly describe, separately as to your ***upper*** denture and ***lower*** denture, your typical application process of Poligrip to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

_____

_____

_____

_____

XIII. Use of Fixodent

If you have used Fixodent denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

A. Date of first use of Fixodent: _____

B. Date of last use of Fixodent (if ongoing, please state): _____

C. If you have discontinued your use of Fixodent, state the reason you stopped using Fixodent:

_____

_____

1. If you discontinued your use of Fixodent, were you advised to stop using Fixodent by a Health Care Provider or Oral Health Care Provider? Yes _____ No_____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: _____

_____

D. Did you use Fixodent continuously during the time period described in (A) and (B) above? _____

E. If you did not use Fixodent continuously, state the dates or time periods you used Fixodent: _____

_____

_____

F. The type(s) of Fixodent you normally use or used (for example, Fixodent Complete, Fixodent Fresh, Fixodent Free, Fixodent Original, Fixodent Comfort, Fixodent Control, Fixodent Control + Scope Flavor, or other): _____

_____

_____

G. The tube size of Fixodent you normally purchase or purchased (for example, 1.4 oz., 2.0 oz., 2.2 oz., 2.4 oz., other):_____

_____

H. If you have used more than one type of Fixodent, state the type and the approximate dates or time periods of use of each: _____

_____

_____

_____

_____

I. The number of times per week you use/used Fixodent (and, if different over time, describe and provide the dates or time periods of each such usage):_____

J. For your ***upper*** denture, the number of times per day you apply/applied Fixodent to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

_____

_____

K. For your ***lower*** denture, the number of times per day you apply/applied Fixodent to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

_____

_____

L. Did you or do you clean your dentures before each application of Fixodent? Yes__ No__ Sometimes ___

1. If you answered yes or sometimes, please describe your denture cleaning process:

_____

_____

_____

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Fixodent? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Fixodent with each appliance: _____

_____

N. Every store or pharmacy where Fixodent was purchased by you or on your behalf and the dates of purchase: _____

_____

_____

_____

O. Identify every Oral Health Care Provider from whom you received Fixodent: _____

_____

_____

P. The number of 2.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 2.4 oz tube every 10 days):_____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

Q. The number of 1.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 1.4 oz tube every 10 days):_____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

R. Briefly describe, separately as to your ***upper*** denture and ***lower*** denture, your typical application process of Fixodent to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

_____

_____

XIV. Request for Production of Documents Directed to Plaintiff(s)

Please produce the following non-privileged documents (including but not limited to emails and internet articles or postings) with this Fact Sheet, to the extent that such documents are currently in your possession or in the possession of your lawyers:

1. All documents you or anyone acting on your behalf reviewed in preparation of this Fact Sheet.

2. A copy of all medical records regarding the Denture Adhesive Cream User from any Health Care Provider who treated the Denture Adhesive Cream User for any disease, condition or symptom referred to in response to the questions above.

3. A copy of all dental records regarding the Denture Adhesive Cream User from any Oral Health Care Provider who has treated the Denture Adhesive Cream User for any reason, including for the care and fitting of dentures.

4. To the extent not included in the foregoing, all records relating to any examination of the Denture Adhesive Cream User by any Health Care Provider or Oral Health

Care Provider, conducted for any purpose during the time period of 10 years preceding your first use of dentures to the present.

5. A copy of any and all purchase receipts showing proof of purchase of Poligrip or Fixodent by the Denture Adhesive Cream User or on his or her behalf.

6. If the Denture Adhesive Cream User has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

7. Reports of all diagnostic tests, including but not limited to blood tests, peripheral blood smears, bone marrow smears or testing, electromyograms, nerve conduction studies, somatosensory evoked potential studies, visual evoked potential studies, brainstem auditory evoked potential studies, other neurological testing, X-rays, MRIs, CT scans, and other imaging studies administered to the Denture Adhesive Cream User at any time.

8. Copies of all documents in your possession from physicians, Health Care Providers, Oral Health Care Providers or others relating to the use of Denture Adhesive Cream, or to any condition you claim is related to the use of Denture Adhesive Cream, or recording or reflecting the use of any Denture Adhesive Cream by the Denture Adhesive Cream User.

9. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts or other materials obtained by the Denture Adhesive Cream User or his or her agents, representatives or anyone acting on the Denture Adhesive Cream User's behalf (other than your attorneys in this case) in connection with the use of any Denture Adhesive Cream, including but not limited to Poligrip and/or Fixodent. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source *other than* the documents that Defendants either have or may produce during the course of discovery in this lawsuit.

10. All prescriptions, prescription records, drug containers and labels, informational brochures, advertisements, package inserts and other documents setting forth warnings and/or instructions relating to any medications, drugs, vitamins or supplements used by the Denture Adhesive Cream User as identified in Section VII of this Fact Sheet.

11. Any diaries, calendars, date books, or other documents which reflect use by the Denture Adhesive Cream User of any medications, drugs, vitamins or supplements and/or which record or reflect the occurrence, duration, or severity of any injury, illness, or disease affecting the Denture Adhesive Cream User within the time period of 10 years preceding your first use of dentures to the present.

12. Any releases, covenants not to sue, and any other agreement(s) between you and any other person relating in any way to the claims asserted in this lawsuit.

13. All press releases or other public statements made by or on behalf of you relating to this litigation (excluding postings on web sites of plaintiffs' attorneys).

14. All documents recording, reflecting or relating to any communication concerning Denture Adhesive Cream (including but not limited to Poligrip and/or Fixodent) that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, pharmaceutical manufacturer or distributor, members of the press or news media, or other person (other than any communication with your lawyers in this case).

15. All documents recording, reflecting or relating to any communication that you or anyone acting on your behalf (including your attorneys) has had with any of the GSK Defendants and/or the P&G Defendants, including but not limited to any electronic or tape recording of any such communication(s).

16. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

17. All documents that relate to Denture Adhesive Creams (including but not limited to Poligrip and/or Fixodent), any alleged side effect of Denture Adhesive Cream, or the alleged injuries that are the subject of this lawsuit. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source *other than* the documents that Defendants either have or may produce during the course of discovery in this lawsuit.

18. All documents relating to Denture Adhesive Creams or any alleged health risks or hazards related to Denture Adhesive Creams in your possession, or the possession of the Denture Adhesive Cream User, at or before the time of the injury alleged in your Complaint.

19. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant.

20. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your complaint (excluding materials prepared by Plaintiffs' experts, the production of which will be separate).

21. All documents that record, reflect or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the administration of any Denture Adhesive Cream as alleged in the Complaint.

22. If your complaint includes a claim of loss of support or loss of earnings or earning capacity, produce all W-2s (if you are an employee) and/or the federal income tax returns (if you are self-employed) of the Denture Adhesive Cream User since 1995 to the present.

23. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

24. Copies of letters testamentary, letters of administration or similar documentation relating to your status as plaintiff (if applicable).

25. Decedent's death certificate (if applicable).

26. Medical or coroner's reports regarding decedent's death (if applicable).

XV. Authorizations

Complete and sign the attached authorizations for release of records.

XVI. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct, that I have supplied all the documents requested in Section XIV of this Plaintiffs' Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____ _____

Signature Date

_____

Printed Name